Mr. Chairman, Ranking Member Cummings, and Ladies and Gentlemen of the Committee—

It is a privilege to sit here before you and be able to address you, the men and women who make up the membership of this committee. As I look beside me, however, it must be recognized that I am the sole female on this panel—a collection of witnesses you have asked discuss access to medication that is only prescribed to women.

If this hearing had been called to discuss the issue of access to erectile dysfunction medication and the panel here consisted solely of women, I would have also argued that your decision was, at best, irrational.

My gender notwithstanding, I hope to present two rational, evidence-based arguments in support of our responsibility to assure that women have access to contraception. There are other arguments we could discuss, but these two highlight the absurdity of obstructing the use of certain classes of safe, effective medications.

First, contraception provides this country with measurable health and economic benefits that have nothing to do with sexual activity. Although they are called "oral contraceptive pills" (OCPs), synthetic estrogen and progesterone are now among the most widely prescribed medications in America. Is that because more women are sexually active? No. It is because these medications have helped millions of women with a diverse array of medical concerns. They are now prescribed for acne, endometriosis, polycystic ovarian syndrome, and as a means of protecting women who are particularly at risk for certain diseases such as ovarian cancer. The health risks involved when access to these drugs is blocked is very real. For example, without OCPs a woman with polycystic ovarian syndrome is exposed to unopposed estrogen, placing her at higher risk for endometrial cancer.

Along these same lines, from a public health standpoint, OCP prescriptions allow more women to attend school and work without having to use previously used sick days for debilitating premenstrual cramps. By denying women diagnosed with dysmenorrhea (painful cramps) or menorrhagia (excessively heavy blood flow) the option of birth control pills, we deny them the current gold standard for treatment. All evidence suggests that health care providers should use these tools to treat female patients. In a nation that has invested such a large portion of funding—about two percent of our annual budget—towards medical research, it is unfortunate that some would ignore this research-based conclusion.

Second, although we may disagree as to the benefits of family planning, we should all recognize that, in this country, it is a doctor's obligation to present a patient with a wide range of reasonable medical choices.

I recently completed a rotation in the nursery of a nearby hospital whose policy is not to offer contraceptives to women. As I was discharging new mothers—most of

whom were immigrants, or poor, or both, with little idea of where to go and what to do after they and their newborns left our care—I was not able to present them with a fair range of options.

Many studies have shown that it is beneficial for women to use some sort of birth control for the first year after delivery. Becoming pregnant any sooner puts the mother, her current child, and the future infant at risk for adverse health outcomes. I struggled to bite my tongue as these mothers left without this important medical advice—information that I freely and routinely provide to other patients at other hospitals. How could this hospital, whose goal is to provide the best healthcare to its patients, deny these women that information?

Regardless of where you stand religiously on the use of contraception, as medical students in the year 2012, we are taught that it is our responsibility as healthcare professionals to provide "patient centered care." We have moved away from the paternalistic view of "doctor knows all," to presenting the evidence and options to patients in order to come to healthcare decisions together as a team. Without presenting the full spectrum of available options, we are reverting back to a paternalistic view that physicians (or politicians) "know" what is best. That view, in my opinion, is wrong.

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